

# Referral for Contraception Services

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ MR #: \_\_\_\_\_

**To:** \_\_\_\_\_ **From:** \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Phone: \_\_\_\_\_

Fax: \_\_\_\_\_ Fax: \_\_\_\_\_

Pertinent Medical History:

\_\_\_\_\_

Medications:

\_\_\_\_\_

Allergies:

\_\_\_\_\_

**Reason for Referral:**

**Referral Appointment:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

- Hormonal Contraception
- IUD
- Diaphragm Fitting
- Cervical Cap Fitting
- Tubal Ligation
- Vasectomy
- Other \_\_\_\_\_

\_\_\_\_\_  
**Signature of Referring Provider**

\_\_\_\_\_  
**Date**